ASSEMBLY BILL No. 2805

Introduced by Assembly Member Ma

February 22, 2008

An act to amend Section 1371.3 of the Health and Safety Code, and to amend Sections 10133 and 10133.7 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2805, as introduced, Ma. Health care coverage: payment for benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires group health care service plans to authorize and permit assignment of a Medi-Cal beneficiary's right to reimbursement for covered services to the State Department of Health Care Services, except as specified.

This bill would make that requirement applicable to individual health care service plans and would require health care service plans to authorize and permit assignment of an enrollee or subscriber's right to reimbursement for covered services to the provider furnishing those services, except as specified.

Because a willful violation of those provisions would be a crime, the bill would impose a state-mandate local program.

Existing law provides for the direct payment of group insurance medical benefits by a health insurer to the person or persons furnishing or paying for hospitalization or medical or surgical aid or, in the case

of a Medi-Cal beneficiary, to the State Department of Health Care Services, as specified.

This bill would make those provisions applicable to individual health insurance policies issued, amended, renewed, or delivered on or after January 1, 2009.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1371.3 of the Health and Safety Code is amended to read:

1371.3. ~~On and after January 1, 1994, every group~~ *A* health care service plan that provides hospital, medical, or surgical expense benefits for plan members and their dependents shall authorize and permit assignment of the enrollee's or subscriber's right to ~~any~~ *a* reimbursement for health care services covered under the plan contract *to the provider furnishing those services or, when health care services are provided to a Medi-Cal beneficiary,* to the State Department of Health *Care* Services ~~when health care services are provided to a Medi-Cal beneficiary~~. This section, however, shall not apply to a Medi-Cal beneficiary for health care services provided pursuant to a contract with the State Department of Health *Care* Services under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 2. Section 10133 of the Insurance Code is amended to read:

10133. (a) Upon written consent of the insured first obtained with respect to a particular claim, ~~any~~ *a* disability insurer shall pay group insurance benefits contingent upon, or for expenses incurred on account of, hospitalization or medical or surgical aid to the person or persons furnishing the hospitalization or medical or surgical aid, or, on and after January 1, 1994, to the person or persons having paid for the hospitalization or medical or surgical

aid, but the amount of ~~any such~~ *that* payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid, and the amount of the payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of the hospitalization or medical or surgical aid. Payments so made shall discharge the insurer's obligation with respect to the amount so paid.

(b) Nothing in this section shall be construed to authorize an insurer to furnish or directly provide services of hospitals, or psychiatric health facilities, as defined in Section 1250.2 of the Health and Safety Code, or physicians and surgeons, or psychologists or in any manner to direct, participate in, or control the selection of the hospital or health facility or physician and surgeon or psychologist from whom the insured secures services or exercise medical or dental or psychological professional judgment, except that an insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and offer the benefit of these alternative rates to insureds who select those providers.

(c) Alternatively, insurers may, by agreement with group policyholders, limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to contract with the insurer.

(d) Pursuant to subdivision (c), when alternate rates of payment to providers are applicable to contracts with group policyholders, the contracts shall include programs for the continuous review of the quality of care, performance of medical or psychological personnel included in the plan, utilization of services and facilities, and costs, by professionally recognized unrelated third parties utilizing in the case of professional providers similarly licensed providers for each medical, psychological, or dental service covered under the plan and utilizing in the case of institutional providers appropriate professional providers. All provisions of the laws of the state relating to immunity from liability and discovery privileges for medical, psychological, and dental peer review shall apply to the licensed providers performing the foregoing activities.

(e) On or after July 1, 1983, the amendments made to this section during the 1982 portion of the 1981–82 Regular Session, shall also

be applicable with respect to both professional and institutional providers.

(f) This section shall apply to individual health insurance policies issued, amended, renewed, or delivered on or after January 1, 2009.

SEC. 3. Section 10133.7 of the Insurance Code is amended to read:

10133.7. (a) On and after January 1, 1994, ~~any~~ *a* disability insurer shall pay group insurance benefits contingent upon, or for expenses incurred on account of, hospitalization or medical or surgical aid to the person or persons having provided or having paid for the hospitalization or medical or surgical aid where that person has qualified for reimbursement by submitting the items and information specified in subdivisions (b) and (c). The amount of ~~any such~~ *that* payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid, and the amount of payments shall not exceed the amount of expenses incurred on account of the hospitalization or medical or surgical aid. Payment so made shall discharge the insurer's obligation with respect to the amount so paid.

(b) The items which shall be submitted to the insurer for reimbursement pursuant to subdivision (a) are as follows:

(1) Proof of payment of medical services and a provider's itemized bill for service.

(2) In the case where the insured does not reside with the person or persons seeking hospitalization or medical or surgical aid, either a copy of the judicial order requiring the insured to provide dependent coverage or a state approved form verifying the existence of a judicial order to be filed with the insurer on an annual basis.

(3) In the case where the insured does not reside with the person or persons seeking hospitalization or medical or surgical aid, and the provider is seeking direct reimbursement, an itemized bill with the signature of the custodial parent or guardian certifying that services being billed for have been provided and, on an annual basis, either a copy of the judicial order requiring the insured to provide dependent coverage or a state approved form verifying the existence of a judicial order.

(c) When seeking payment from an insurer, a person shall provide an insurer the items specified in subdivision (b) with the

name and address of the person to be reimbursed, the name and policy number of the insured, the name of the individual for whom hospitalization or medical or surgical aid has been provided, and other necessary information directly related to coverage under the policy.

(d) In the case of a Medi-Cal beneficiary, where the State Department of Health *Care* Services has paid for the hospitalization or medical or surgical aid, ~~any~~ *a* disability insurer shall pay group insurance benefits to the State Department of Health *Care* Services for expenses contingent upon, or incurred on account of hospitalization or medical or surgical aid. Payment so made shall discharge the insurer's obligation with respect to the amount so paid. The amount of ~~any such~~ *that* payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid, and the amount of payments shall not exceed the amount of expenses incurred on account of hospitalization or medical or surgical aid.

(e) This section shall apply to individual health insurance policies issued, amended, renewed, or delivered on or after January 1, 2009.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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